UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

REMICADE (infliximab)**for JUVENILE IDIOPATHIC ARTHRITIS**

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Physician's NPI_____

Diagnosis_____Current wt_____mg/kg_____

Administered every_____weeks starting (date)_____

All information to be legible, complete and correct or form will be returned

---

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- Age requirement: 4 years old and older
- Diagnosis of Juvenile Idiopathic Arthritis.
- Documentation of failed treatment on at least one DMARD.
- Negative TB skin test or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Rheumatology consultation within the last 60 days.
- May not be given with other biologic agents such as Interferon, experimental medications or combinations.

INFORMATION:

To be given in clinic setting only. Patients on HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code J1745 and PA number.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance with medication.

7/10/08